		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I.

IDPH Facility ID Number: 0032946

Facility Name: LITCHFIELD TERRACE

Address: 1024 E. TYLER STREET (Number) LITCHFIELD (City) 62056 (Zip Code)

County: MONTGOMERY

Telephone Number: (217) 324-3842 **Fax #** (217) 324-3942

IDPA ID Number: 37-1223347

Date of Initial License for Current Owners: 11/06//87

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) MELVIN SIEGEL
(Title) PRESIDENT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number LITCHFIELD TERRACE # 0032946 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	65	Intermediate (ICF)	65	23,725	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	65	TOTALS	65	23,725	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	21,286	591		21,877	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,286	591		21,877	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.21%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/06/87

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/06/87 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number LITCHFIELD TERRACE # 0032946 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	84,167	6,161	5,110	95,438		95,438	0	95,438			1
2	Food Purchase		83,917		83,917	(12,333)	71,584	(324)	71,260			2
3	Housekeeping	46,382	7,525	0	53,907		53,907	0	53,907			3
4	Laundry	26,007	8,076	1,615	35,698		35,698	0	35,698			4
5	Heat and Other Utilities			51,351	51,351		51,351	726	52,077			5
6	Maintenance	28,047	14,030	18,332	60,409		60,409	(4,460)	55,949			6
7	Other (specify):*			2,707	2,707		2,707	62	2,769			7
8	TOTAL General Services	184,603	119,709	79,115	383,427	(12,333)	371,094	(3,996)	367,098			8
	B. Health Care and Programs											
9	Medical Director	0		6,325	6,325		6,325	0	6,325			9
10	Nursing and Medical Records	476,850	16,015	4,404	497,269		497,269	6,301	503,570			10
10a	Therapy	0		0	0		0	0	0			10a
11	Activities	33,562	1,480	3,120	38,162		38,162	(3,027)	35,135			11
12	Social Services	74,145	205	0	74,350		74,350	0	74,350			12
13	Nurse Aide Training			0	0		0	0	0			13
14	Program Transportation			0	0		0	0	0			14
15	Other (specify):*				0		0	0	0			15
16	TOTAL Health Care and Programs	584,557	17,700	13,849	616,106	0	616,106	3,274	619,380			16
	C. General Administration											
17	Administrative	34,944		0	34,944		34,944	12,430	47,374			17
18	Directors Fees			0	0		0	0	0			18
19	Professional Services			118,420	118,420		118,420	(72,543)	45,877			19
20	Dues, Fees, Subscriptions & Promotions			6,217	6,217		6,217	(1,860)	4,357			20
21	Clerical & General Office Expenses	56,675	14,366	14,205	85,246		85,246	32,884	118,130			21
22	Employee Benefits & Payroll Taxes			134,529	134,529	12,333	146,862	0	146,862			22
23	Inservice Training & Education			2,099	2,099		2,099	137	2,236			23
24	Travel and Seminar			457	457		457	12,653	13,110			24
25	Other Admin. Staff Transportation			2,205	2,205		2,205	0	2,205			25
26	Insurance-Prop.Liab.Malpractice			22,520	22,520		22,520	1,154	23,674			26
27	Other (specify):*			0	0		0	9,820	9,820			27
28	TOTAL General Administration	91,619	14,366	300,652	406,637	12,333	418,970	(5,325)	413,645			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	860,779	151,775	393,616	1,406,170	0	1,406,170	(6,047)	1,400,123			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number LITCHFIELD TERRACE #0032946 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			4,404	4,404		4,404	20,056	24,460			30
31	Amortization of Pre-Op. & Org.				0		0	0	0			31
32	Interest			22,323	22,323		22,323	105,962	128,285			32
33	Real Estate Taxes			13,678	13,678		13,678	0	13,678			33
34	Rent-Facility & Grounds			104,689	104,689		104,689	(98,162)	6,527			34
35	Rent-Equipment & Vehicles			3,941	3,941		3,941	5,238	9,179			35
36	Other (specify):*				0		0	0	0			36
37	TOTAL Ownership			149,035	149,035	0	149,035	33,094	182,129			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers				0		0	0	0			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			35,587	35,587		35,587	0	35,587			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	0	35,587	35,587	0	35,587	0	35,587			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	860,779	151,775	578,238	1,590,792	0	1,590,792	27,047	1,617,839			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number LITCHFIELD TERRACE # 0032946 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,017	30		9
10	Interest and Other Investment Income	(3)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(324)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(300)	21		18
19	Entertainment	0	20		19
20	Contributions	(1,574)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	0	27		24
25	Fund Raising, Advertising and Promotional	(635)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	0	20		28
29	Other-Attach Schedule SEE PAGE 5A	0			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,819)		$ 0	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	28,866		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 28,866		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 27,047		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

LITCHFIELD TERRACE

ID# 0032946

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number LITCHFIELD TERRACE # 0032946 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(324)	0	0	0	0	0	0	0	0	0	0	(324)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	726	0	0	0	0	0	0	0	0	0	726	5
6	Maintenance	0	(4,460)	0	0	0	0	0	0	0	0	0	(4,460)	6
7	Other (specify):*	0	62	0	0	0	0	0	0	0	0	0	62	7
8	**TOTAL General Services**	(324)	(3,672)	0	0	0	0	0	0	0	0	0	(3,996)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	6,301	0	0	0	0	0	0	0	0	0	6,301	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	(3,027)	0	0	0	0	0	0	0	0	0	(3,027)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	3,274	0	0	0	0	0	0	0	0	0	3,274	16
	C. General Administration													
17	Administrative	0	10,411	2,019	0	0	0	0	0	0	0	0	12,430	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(72,543)	0	0	0	0	0	0	0	0	0	(72,543)	19
20	Fees, Subscriptions & Promotions	(2,209)	349	0	0	0	0	0	0	0	0	0	(1,860)	20
21	Clerical & General Office Expenses	(300)	0	33,184	0	0	0	0	0	0	0	0	32,884	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	137	0	0	0	0	0	0	0	0	137	23
24	Travel and Seminar	0	0	12,653	0	0	0	0	0	0	0	0	12,653	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,154	0	0	0	0	0	0	0	0	1,154	26
27	Other (specify):*	0	0	9,820	0	0	0	0	0	0	0	0	9,820	27
28	**TOTAL General Administration**	(2,509)	(61,783)	58,967	0	0	0	0	0	0	0	0	(5,325)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(2,833)	(62,181)	58,967	0	0	0	0	0	0	0	0	(6,047)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number LITCHFIELD TERRACE **#** 0032946 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	1,017	0	330	18,709	0	0	0	0	0	0	0	20,056	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3)	0	0	105,965	0	0	0	0	0	0	0	105,962	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	6,527	(104,689)	0	0	0	0	0	0	0	(98,162)	34
35	Rent-Equipment & Vehicles	0	0	5,238	0	0	0	0	0	0	0	0	5,238	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	1,014	0	12,095	19,985	0	0	0	0	0	0	0	33,094	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,819)	(62,181)	71,062	19,985	0	0	0	0	0	0	0	27,047	45

Facility Name & ID Number LITCHFIELD TERRACE # 0032946 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED LIST		ARC OF JACKSONVILLE	JACKSONVILLE	MAVIN	CHICAGO	CONSULTING,
		PARK RIDGE TERRACE	LOVER PARK	ENTERPRISES LTD		BOOKKEEPING
		PARKVIEW TERRACE	EAST MOLINE			
		SKYVIEW TERRACE	JACKSONVILLE			
		SPRINGFIELD TERRACE	SPRINGFIELD			
		VANDALIA TERRACE	VANDALIA			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	6	MAINTENANCE CONSULT	$ 11,580	MAVIN ENTERPRISES, LTD.		$	$ (11,580)	1
2	V	10	PSYCHO-SOCIAL CONSULT	3,513				(3,513)	2
3	V	11	ACTIVITIES CONSULT	3,120				(3,120)	3
4	V	19	ADMIN./BKKP. FEES	55,560				(55,560)	4
5	V	19	ADMIN./CONSULT. FEES	18,960				(18,960)	5
6	V	5	ELECTRICITY				726	726	6
7	V	6	MAINTENANCE				7,120	7,120	7
8	V	7	SCAVENGER				62	62	8
9	V	10	PSYCHO-SOCIAL CONSULT				9,814	9,814	9
10	V	11	ACTIVITIES CONSULTANT				93	93	10
11	V	17	ADMIN. SALARIES/MGMT				10,411	10,411	11
12	V	19	PROFESSIONAL FEES				1,977	1,977	12
13	V	20	ADVERTISING				349	349	13
14	Total			$ 92,733			$ 30,552	$ * (62,181)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number LITCHFIELD TERRACE # 0032946 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	TOTAL OFFICE	$	MELVIN ENTERPRISES, LTD.		$ 33,184	$ 33,184	15
16	V	23	SEMINARS				137	137	16
17	V	24	TRAVEL				12,653	12,653	17
18	V	26	INSURANCE				1,154	1,154	18
19	V	27	EMPLOYEE BENEFITS				9,820	9,820	19
20	V	30	DEPRECIATION (SL)				330	330	20
21	V	34	OFFICE RENT				6,527	6,527	21
22	V	35	EQUIPMENT RENT				5,238	5,238	22
23	V	17	MGMT FEES - SWS				2,019	2,019	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 71,062	$ * 71,062	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number LITCHFIELD TERRACE # 0032946 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	$ 104,689	IDEA ASSOCIATES		$	$ (104,689)	15
16	V	30	DEPRECIATION				18,709	18,709	16
17	V	32	INTEREST				105,965	105,965	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 104,689			$ 124,674	$ * 19,985	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number LITCHFIELD TERRACE # 0032946 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8					SEE ATTACHED LIST						8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number LITCHFIELD TERRACE # 0032946 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: MAVIN ENTERPRISES, LTD.
Street Address: 3845 OAKTON
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-0100
Fax Number: (847) 679-0647

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	ELECTRICITY	PATIENT DAYS	151,711	7	$ 5,036	$	21,877	$ 726	1
2	6	MAINTENANCE	PATIENT DAYS	151,711	7	49,373		21,877	7,120	2
3	7	SCAVENGER	PATIENT DAYS	151,711	7	432		21,877	62	3
4	10	PSYCHO-SOCIAL CONSULT	PATIENT DAYS	151,711	7	68,057		21,877	9,814	4
5	11	ACTIVITIES CONSULTANT	PATIENT DAYS	151,711	7	646		21,877	93	5
6	17	ADMIN. SALARIES/MGMT	PATIENT DAYS	151,711	7	72,200	72,200	21,877	10,411	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	151,711	7	13,709		21,877	1,977	7
8	20	ADVERTISING	PATIENT DAYS	151,711	7	2,417		21,877	349	8
9	21	TOTAL OFFICE	PATIENT DAYS	151,711	7	230,125	144,338	21,877	33,184	9
10	23	SEMINARS	PATIENT DAYS	151,711	7	950		21,877	137	10
11	24	TRAVEL	PATIENT DAYS	151,711	7	87,742		21,877	12,653	11
12	26	INSURANCE	PATIENT DAYS	151,711	7	8,000		21,877	1,154	12
13	27	EMPLOYEE BENEFITS	PATIENT DAYS	151,711	7	68,102		21,877	9,820	13
14	30	DEPRECIATION (SL)	PATIENT DAYS	151,711	7	2,285		21,877	330	14
15	34	OFFICE RENT	PATIENT DAYS	151,711	7	45,262		21,877	6,527	15
16	35	EQUIPMENT RENT	PATIENT DAYS	151,711	7	36,325		21,877	5,238	16
17	17	MGMT FEES - SWS	PATIENT DAYS	151,711	7	14,000		21,877	2,019	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 704,661	$ 216,538		$ 101,614	25

Facility Name & ID Number LITCHFIELD TERRACE # 0032946 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: IDEA ASSOCIATES
Street Address: 3845 OAKTON
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-0100
Fax Number: (847) 679-0647

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION	DIRECT COST	1	1	$ 18,709	$	1	$ 18,709	1
2	32	INTEREST	DIRECT COST	1	1	105,965		1	105,965	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 124,674	$		$ 124,674	25

Facility Name & ID Number LITCHFIELD TERRACE # 0032946 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	RELATED PARTY						$	$			$	1
2	IDEA											2
3	SUCCESS NATIONAL BANK			MORTGAGE	DEMAND	10/98	874,500	858,054	10/03	9.5000	105,965	3
4												4
5												5
	Working Capital											
6	SUCCESS NATIONAL BANK		X	LINE OF CREDIT		11/01/97	150,000	151,997		10.5000	7,119	6
7	IDEA ASSOCIATES	X		DEBT CONSOLIDATION		10/18/98	247,102	162,652		9.5000	15,204	7
8												8
9	TOTAL Facility Related						$ 1,271,602	$ 1,172,703			$ 128,288	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ 0	14
15	TOTALS (line 9+line14)						$ 1,271,602	$ 1,172,703			$ 128,288	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number LITCHFIELD TERRACE # 0032946 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 12,674	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 13,678	2
3. Under or (over) accrual (line 2 minus line 1).		$ 1,004	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 12,674	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 13,678	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	11,669	8
	1997	12,535	9
	1998	12,284	10
	1999	12,674	11
	2000	13,678	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2000 TAX BILL.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME LITCHFIELD TERRACE COUNTY MONTGOMERY

FACILITY IDPH LICENSE NUMBER 0032946

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200(

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	16-001-925-00	NURSING HOME	$ 13,678.16	$ 13,678.16
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 13,678.16	$ 13,678.16

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services' _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

Facility Name & ID Number LITCHFIELD TERRACE # 0032946 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 0 B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1		0		$	1
2					2
3	TOTALS			$ 0	3

Facility Name & ID Number LITCHFIELD TERRACE # 0032946 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	65		1987		$ 589,342	$ 18,709	31.5	$ 18,709	$	$ 205,744	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS			1989	12,200	127	20	610	483	2,793	9
10	VARIOUS			1990	11,968	349	20	598	249	3,695	10
11	VARIOUS			1991	4,250	135	20	212	77	4,863	11
12	VARIOUS			1992	14,226	197	20	711	514	4,142	12
13	VARIOUS			1993	5,350	170	20	268	98	6,246	13
14	VARIOUS			1994	2,312	25	20	116	91	5,302	14
15	GARBAGE DISPOSAL			1996	695	0	20	35	35	187	15
16	TILE			1997	2,778	71	20	139	68	571	16
17	WATER HEATER			1998	2,107	54	20	105	51	367	17
18	AIR CONDITIONERS			2000	1,477	54	27.5	54	54	82	18
19	REPAIR ROOF			2000	1,700	62	27.5	62	62	94	19
20	SPRINKERS			2000	2,961	108	27.5	108	108	164	20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number LITCHFIELD TERRACE # 0032946 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 651,366	$ 20,061		$ 21,727	$ 1,890	$ 234,250	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number LITCHFIELD TERRACE # 0032946 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 42,358	$ 2,941	$ 2,125	$ (816)	8-10	$ 30,234	71
72	Current Year Purchases	5,567	111	278	167	10	278	72
73	Fully Depreciated Assets	742			0		742	73
74	MAVIN ALLOCATION		330	330	0			74
75	TOTALS	$ 48,667	$ 3,382	$ 2,733	$ (649)		$ 31,254	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$ 0		$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			$ 0	$ 0	$ 0	$ 0		$ 0	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 700,033	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 23,443	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 24,460	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 1,017	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 265,504	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? ☐ YES ☐ NO
If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 1,991 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY	2000 DODGE RAM	$ 650.00	$ 1,950	17
18					18
19					19
20					20
21	TOTAL		$ 650.00	$ 1,950	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number LITCHFIELD TERRACE # 0032946 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	Nurse Aide Competency Tests				0
9	TOTALS	$ 0	$ 0	$ 0	$ 0
10	SUM OF line 9, col. 1 and 2 (e)	$ 0			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number LITCHFIELD TERRACE # 0032946 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number LITCHFIELD TERRACE # 0032946 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,011	$	1
2	Cash-Patient Deposits	815		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	348,703		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	3,872		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	1,439,156		8
9	Other(specify): Real Estate Tax Escrow	11,184		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,804,741	$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	42,760		15
16	Equipment, at Historical Cost	64,332		16
17	Accumulated Depreciation (book methods)	(67,729)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): DEPOSITS	1,453		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 40,816	$ 0	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,845,557	$ 0	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 242,484	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	345,869		29
30	Accrued Salaries Payable	35,564		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,037		31
32	Accrued Real Estate Taxes(Sch.IX-B)	12,674		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 637,628	$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 0	$ 0	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 637,628	$ 0	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,207,929	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,845,557	$ 0	48

***(See instructions.)**

Facility Name & ID Number LITCHFIELD TERRACE # 0032946 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,201,617	1
2	Restatements (describe):		2
3	ILLINOIS REPLACEMENT TAX	(2,110)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,199,507	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	8,530	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) TREASURY STOCK	(108)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 8,422	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,207,929	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number LITCHFIELD TERRACE # 0032946 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,599,319	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,599,319	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 0	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 0	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,599,322	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	383,427	31
32	Health Care	616,106	32
33	General Administration	406,637	33
	B. Capital Expense		
34	Ownership	149,035	34
	C. Ancillary Expense		
35	Special Cost Centers	0	35
36	Provider Participation Fee	35,587	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,590,792	40
41	**Income before Income Taxes (line 30 minus line 40)****	8,530	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 8,530	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number LITCHFIELD TERRACE # 0032946 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,969	2,037	$ 41,284	$ 20.27	1
2	Assistant Director of Nursing					2
3	Registered Nurses	250	274	4,997	18.24	3
4	Licensed Practical Nurses	11,166	12,559	170,301	13.56	4
5	Nurse Aides & Orderlies	26,498	28,567	213,679	7.48	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,555	3,833	33,562	8.76	10
11	Social Service Workers	6,379	6,796	74,145	10.91	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	9,694	10,340	84,167	8.14	15
16	Dishwashers					16
17	Maintenance Workers	2,928	3,257	28,047	8.61	17
18	Housekeepers	5,412	6,111	46,382	7.59	18
19	Laundry	2,953	3,404	26,007	7.64	19
20	Administrator	1,964	2,096	34,944	16.67	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,696	6,928	56,675	8.18	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,670	1,861	15,613	8.39	31
32	Other Health Care(specify)					32
33	Other(specify) Care Plan Coord	1,616	1,801	30,976	17.20	33
34	TOTAL (lines 1 - 33)	82,750	89,864	$ 860,779 *	$ 9.58	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 5,110	1-3	35
36	Medical Director	O	6,325	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	651	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	F	3,120	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	E			46
47	PSYCHO-SOCIAL CONSULTANT	S	3,513	10-3	47
48					48
49	TOTAL (lines 35 - 48)		$ 18,719		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	8	240	10-3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	8	$ 240		53

Facility Name & ID Number LITCHFIELD TERRACE # 0032946 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
AUDREY CALCARI	ADMIN	0	$ 34,944
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 34,944

B. Administrative - Other

Description	Amount
	$ 0
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
MID AMERICA PROGRAM	DATA PROCESSING	$ 1,320
RAYMOND E. MCALPIN	LEGAL FEES	2,668
MEVIN ENTERPRISES	ADM. CONSULTANT	18,960
GARY WEINTRAUB	LEGAL FEES	3,025
ACE TAX & LEGAL CONSUL.	LEGAL FEES	750
TENNEY & BENTLEY	LEGAL FEES	21,223
KRUPNICK, BOKOR	ACCOUNTING FEES	7,900
SUCCESS NATIONAL BANK	AUDIT	1,225
PERSONNEL PLANNERS	UC CONSULTANT	683
NCS,ALPHA DATA SERVICES	DATA PROCESSING	5,106
MEVIN ENTERPRISES	BOOKKEEPING/ADMIN.	55,560
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 118,420

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 21,606
Unemployment Compensation Insurance	10,513
FICA Taxes	66,123
Employee Health Insurance	33,862
Employee Meals	12,333
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	2,425
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	0
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 146,862

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	1,061
Health Care Worker Background Check	0
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	635
MGMT CO ALLOCATION	349
CONTRIBUTIONS	1,574
DUES & SUBSCRIPTIONS	2,497
LICENSES & PERMITS	50
TRUST FEES/CONTRIBUTIONS	(1,574)
Less: Public Relations Expense	(0)
Non-allowable advertising	(635)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,357

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	457
MGMT CO ALLOCATION	12,653
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 13,110

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number LITCHFIELD TERRACE # 0032946 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10							N/A						
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number LITCHFIELD TERRACE # 0032946 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL LONG TERM CARE $2362**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **35,587**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **12,333** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: LITCHFIELD TERRACE **#0032946** **Report Period Beginning: 01/01/2001** **Ending: 12/31/2001**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	5,110	
	REPAIRS & MAINTENANCE		0	
			0	5,110
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		1,615	
			0	1,615
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		8,010	
	ELECTRICITY		33,521	
	WATER		9,460	
	CABLE TV - LOBBY		360	
			0	51,351
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		2,125	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE CONSULTANT		11,580	
	EQUIPMENT MAINTENANCE & REPAIR		424	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		1,713	
	FIRE SERVICE		2,490	
			0	
			0	
			0	18,332
7	**OTHER**			
	SCAVENGER		2,349	
	SECURITY SERVICE		358	2,707
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	6,325	6,325

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	240	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	3,513	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	651	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	4,404
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	0
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	3,120	
			0	3,120
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	0
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number LITCHFIELD TERRACE **#0032946** **Report Period Beginning: 01/01/2001** **Ending: 12/31/2001**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	0	0
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	6,426	
	ADMINISTRATIVE CONSULTANTS	XIX C	18,960	
	PROFESSIONAL FEES	XIX C	37,474	
	BOOKKEEPING/ADMINISTRATIVE SERVICE		55,560	118,420
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	635	
	EMPLOYEE WANT ADS	XIX F	1,061	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	2,497	
	LICENSES & PERMITS	XIX F	450	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	1,574	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	6,217
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES		1,439	
	EQUIPMENT REPAIR & MAINTENANCE		145	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	300	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		12,321	
	MESSENGER SERVICE		0	
			0	14,205

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	66,123	
	UNEMPLOYMENT COMPENSATION	XIX D	10,513	
	WORKERS COMPENSATION INSURANC	XIX D	21,606	
	HOSPITALIZATION INSURANCE	XIX D	33,862	
	EMPLOYEE BENEFITS - OTHER	XIX D	2,425	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	134,529
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		2,099	2,099
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	457	
			0	
			0	457
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		2,205	2,205
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		22,520	22,520
27	**OTHER**			
	BAD DEBTS	VI 24	0	
			0	0

GRAND TOTAL COLUMN 3 OTHER 393,616

LITCHFIELD TERRACE
EMPLOYEE MEAL RECLASSIFICATION
12/31/2001

TOTAL FOOD PURCHASE	83,917
LESS SALES TAX	(324)
NET FOOD	83,593
TOTAL PATIENT CENSUS	21,877
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	65631
ADD # EMPLOYEE MEALS/DAY	31
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	11315

PATIENT MEALS	65631
ADD EMPLOYEE MEALS	11315
TOTAL MEALS/YEAR	76946
NET FOOD	83593
DIVIDE TOTAL MEALS/YEAR	76946
COST PER MEAL	1.09
TIME EMPLOYEE MEALS	11315
EMPLOYEE MEAL RECLASSIFICATION	12333